COORDINATED COMMUNITY HEALTH-CARE PROGRAMS*

WALTER WENKERT

Director, Health Division, Council of Social Agencies of Rochester and Monroe County, Inc.
Rochester, N Y.

COORDINATION implies separate services that need to be related to each other. These separate services should have a common goal—service appropriate to the immediate needs of the patient—but, perhaps, different immediate objectives and methods. The services may function sequentially, as when the patient moves—or should move—from general hospital care to home care. Or they may function concommitantly, as when care by a physician, public health nursing, and homemaker services are to assist the patient in his own home.

When a living-in institution, such as a hospital, undertakes to provide—as it must—multiple services, the problem of coordination is simplified, at least theoretically. One must assume that the hospital administration has some clear-cut conceptions of the present and long-range goals of the hospital and the specific objectives of its separate services. Yet we know that such internal coordination is not always achieved in living-in or home-care or ambulant-care agencies.

The problem of coordination in the community is no different, but far more complex. For the wide variety of community health services grew, and continue to grow, in response to effective demand from a wide variety of local, state, and federal government sources, from voluntary service-oriented and voluntary disease-oriented sources.

The so-called pattern of community care is in reality a hodge-podge. The word "pattern" implies a community inventory of the range of patient needs and a definition of the services necessary in a total spectrum of care.[1] It implies, also, a systematic way of collecting and analyzing administrative and service data from our community health services in toto. We are failing to take either of these first steps in coordination and planning.

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Initial efforts to make such an inventory have started by defining acute hospital care, long-term hospital care, rehabilitation-directed nursing care, extended and palliative nursing care, and congregate living—all on the institutional side—and organized home care, home care (public health nursing under medical supervision), and foster family care on the noninstitutional side. This inventory concept varies from community to community and, with the passing of time, in the same community. Usually it is undertaken as part of a study that looks beyond the names on the doors of institutions to the type of patients that are being treated. We have had to do this in Rochester on several occasions; once during the time of the Monroe County Chronic Illness Study[2] and now in connection with a study of health-care services required by persons aged 65 and over.[3]

If the reasoning is, then, that a redefinition of existing and needed services followed by reorganizations and additions will create a series of related, different, coordinate-able services, the logic is excellent. The chance of its happening is somewhat less than excellent.

To be specific: for our purposes, a community is an aggregation of people living on a piece of geography who can potentially function to effect changes in their health-care services. In this sense we live in several communities—local, regional, and national. The community is made up of consumers of service, financers of service (who are also consumers), and providers of service (who are also consumers and financers). But the cards are heavily stacked against the premise that the community deliberately can create a new total set of community goals, specific services, and a reorganization of financing mechanism.

To do so, the providers of service first will need to understand that common goals are shared by the following: short-term voluntary hospitals; long-term hospitals, usually governmental; voluntary agencies providing ambulant- and home-care services, such as rehabilitation centers and visiting nurse associations; mental health departments; health departments; welfare departments; professional organizations of physicians, nurses, and the like; financing groups, such as city, county, and state governments; and Blue Cross-Blue Shield. The McKeown concept of the "balanced hospital community" theoretically can be implemented by a few far-sighted administrators, as is happening both here and in England. Our objective, however, is the "balanced community" and, by implication, the acute general hospital, the long-term

hospital–both chronic and mental–the nursing-care facilities in homes for the aged and private nursing homes, and the various types of outpatient and home care–all must be looked at as parts of a total pattern of community care.

Community Leadership

This objective and its implementation require organization and administration. But who "organizes" this total community of care? Can the official agency do this alone? About 20 per cent of medical care is financed by government funds, roughly another 20 per cent by insurance, the rest by direct payment of patients.[4] Hill-Burton funds for capital construction give the granting agency a powerful lever, but the community must still raise the bulk of capital funds–and 3 years of operating expense is greater than the initial expense of capital construction.

Since the community will receive the services and pay the bill, the logical choice would seem to be to rely on the controls and the direction that the community can provide through enlightened lay and professional leadership.

To accomplish this the community will need a permanent planning mechanism with authority to implement its recommendations. Such a mechanism must have a broad community base so that its decisions are not skewed by the biases of individual leaders or of professional or institutional groups. Ideally the mechanism should include a working arrangement of all health and social professions, and voluntary and governmental financing services. Yet it must be free to move with vigor when it reaches a conclusion.

One of the difficulties in achieving this goal is that the hospital oriented to short-term care is the dominant health-care group in the community. Its professional and lay leadership tends to be concerned with the need yesterday, today, and tomorrow for more acute-care beds. The administrator and the board of trustees have less than complete control of the way physicians use the hospital beds. Physicians and health insurance are bed-oriented rather than being oriented from outpatient service or home-care service. Administration may have established in some hospitals, and with some success, the kind of physician concern about costs that makes a hospital utilization committee possible. But there is no evidence that this spotty cost-consciousness will change

the primary concern with hospital bed availability.

The Blue Cross then is in a curious dilemma. If it does not police hospital use its premiums go up and the commercial carriers take away its business. If it does police hospital use, the employer contributing groups get the complaints of irate employees denied "benefits," and Blue Cross is again the butt of the competitive struggle. If Blue Cross sees the community need for outpatient, home care, and chronic living-in care and attempts to cover these without experience rating, Blue Cross must yield again to higher premiums and to the employer tendency to turn to the lower premiums and lower benefits of the experience-rating commercial plans.

The community dilemma in attempting to plan across the board for the "balanced community" is further handicapped by reason of the divisive fashion in which federal construction funds are allocated. Federal Hill-Burton funds siphon through state health departments on the advice of hospital-planning groups that often have little interest in matters other than general hospital beds. Federal mental health funds and mental retardation funds will siphon from the National Institute of Mental Health through state mental hygiene departments, presumably on the advice of regional or local planning groups having a different geographic base and different membership from the hospital-planning groups. And both the hospital-planning groups and the mental health-planning groups have an uncertain relationship to the traditional health and welfare council, which has had an historical concern with community services. We shall find in our communities, therefore, as many as three or more community-planning bodies.

In sum, the situation is hardly calculated to assist professional and lay persons to emphasize the ambulant- and home-care services that can prevent or shorten the patient hospital stay and potentially hold the rising costs of medical care within reasonable bounds. Must one, then, give up all hope? Or is it more sensible to take the position that the hodgepodge we now have was hardly created in a day—and can hardly be cleared up in a day.

Our experience in Rochester and Monroe County is that we are plagued with all the difficulties enumerated above—primary emphasis on beds, Blue Cross difficulty in controlling costs and broadening the insurance base, and multiple planning efforts and allegiances. We do not yet have a total inventory or a total approach to planning. But

if we simply inventory in our community current "new" services created to minimize the need for institutional care, the effort is impressive, if piecemeal.

First, there are three new demonstration studies currently supported in part by funds from the Community Health Services Facilities Act.

1. A study demonstration by the Health Department to test the value of a public health nurse working with physicians and social workers in early planning for the post-hospital care of chronically ill patients.

2. A study demonstration by the Visiting Nurse Service of a new concept: a Personalized Service Bureau designed to discover what factors may be causing the older person to decide he can no longer manage on his own and must seek the sheltering arms of an institution. The dentist, or carpenter, or chiropodist, or friendly visitor will be brought in to discover whether the fixed denture, or new grab rail, or less aching feet, or more social contact will tip the scales in the direction of helping an aged person to manage on his own.

3. A Foster Family Care Program for the Aging, available to welfare and nonwelfare clients alike, is being sponsored by the Council of Homes, a voluntary association of homes for the aged.

Second, the community has used state funds for study demonstrations. Here are two examples.

1. The Home Care Association, Inc., with a board representing all key agences concerned with organized home care, is in the fourth year of its demonstration. It has a state health department subsidy.

2. Two voluntary agencies serving the mentally retarded have just completed major demonstration projects assisted by state funds channeled through the State Department of Mental Hygiene. These projects focused on preschool, adolescent, vocational, and counseling services to the mentally retarded. They now have support from community funds, both governmental and voluntary.

Third, some of our demonstration-study projects have their primary support from local funds.

1. The Hospital Fund Drive's decision that it would limit new acute beds, but would make money available for extended nursing care beds for chronic patients, was primarily supported by local finances with assistance from Hill-Burton funds.

2. In the last eight years, our eight voluntary homes for the aged

have accepted responsibility for establishing nursing care units for chronically ill patients. This was made possible essentially by the support provided by the local welfare department's payment of actual costs, and by Community Chest and other forms of local support, in addition to some Hill-Burton financing.

3. The current effort to develop a meaningful affiliation between the County Infirmary and the School of Medicine will be, if it succeeds, the best example of the effective use of lay and professional concern about quality care supported primarily by local funds.

This, then, is not a current record of complete success in relating services. It is a record of small steps taken by many agencies and several planning groups toward this goal. The difficulties caused by lack of a common philosophy of goals for health care and by varying degrees of readiness to work at integrating and coordinating services make it obvious that community planning will probably continue to be frustrating and fascinating, with small increments of success resulting from continued efforts.

Coordination cannot result from improving interagency referral forms. It can come about only as lay and professional leaders, whatever their affiliation, accept the responsibility to define existing services and establish needed services so that there will be a total range of needed home care and institutional services—all of them comparable in quality and in teaching and research emphasis. To attain this goal, funds derived from private, tax, and insurance sources will need to become as available to the long-term care and home-care services as they have traditionally been to acute hospital-care services.

NOTES AND REFERENCES

1. Stewart, W. H. Who Gets What Care and How, in *The Health Care Issues of the 1960's.* New York, Group Health Insurance, 1961. (See this publication for a detailed analysis of the use, mortality, care, and financing picture nationally.)
2. Wenkert, W. and Terris, M. Methods and findings in a local chronic illness study, *Amer. J. Public Health 50*:9, 1960.
3. University of Rochester School of Medicine and Dentistry, Patient Care Planning Council, and Council of Social Agencies. Monroe County Health Care of Aged Study. In preparation.
4. Stewart, W. H. *Op. cit.,* p. 29.